Bureau of Health Care Quality & Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS5528AGC	A. BUILDING _____ B. WING _____	12/01/2009

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW CREEK AT SAN MARTIN	8374 COPAVILLA AVE LAS VEGAS, NV 89113

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 000	Initial Comments Surveyor: 28276 The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. This Statement of Deficiencies was generated as a result of an annual State Licensure survey and a complaint investigation conducted in your facility on 12/1/09. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility is licensed for 131 Residential Facility for Group beds for elderly and disabled persons, Category II residents. The census at the time of the survey was 53. Sixteen resident files were reviewed and 15 employee files were reviewed. One discharged resident file was reviewed. The facility received a grade of B. Complaint #NV00021971 was unsubstantiated. The following deficiencies were identified:	Y 000		
Y 026 SS=D	449.190(3) Contents of License-Multiple Types NAC 449.190 3. A residential facility may be licensed as more than one type of residential facility if the facility provides evidence satisfactory to the bureau that it complies with the requirements for each type of facility and can demonstrate that the residents will be protected and receive necessary care and services.	Y 026		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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Y 026	Continued From page 1 This Regulation is not met as evidenced by: Surveyor: 27364 Based on interview and observation on 12/1/09, the facility failed to ensure 2 of 15 residents were appropriately placed (Resident #3 and #7). Findings include: Resident #3 was transferred from Palms Memory Care to the facility on 11/24/08. Record review revealed a progress note dated 10/8/09, from the resident's physician documenting a diagnosis of Alzheimer's dementia. A cognitive skills test was administered to Resident #3. Resident #3 was oriented to person, not time and place. Resident #3 was unable to articulate how he would evacuate the facility in case of a fire. Employee #7 stated Resident #3 has wandered with-in the facility, and his cognitive abilities were declining. Resident #7's file contained a Nursing Facility Visit note dated 2/2/6/09 documenting a diagnosis of dementia with psychosis. Resident #7 was prescribed Namenda 10 milligrams twice a day. A hospice note dated 11/27/09, documented Resident #7's diagnosis as end stage dementia. A cognitive skills test was administered to Resident #7. Resident #7 was oriented to person, not time and place. Resident #3 was unable to articulate how she would evacuate the facility in case of a fire. Severity: 2 Scope: 1	Y 026		
Y 255 SS=F	449.217(6)(a)(b) Permits - Comply with NAC 446 NAC 449.217	Y 255		

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Y 255	Continued From page 2 6. A residential facility with more than 10 residents must: (a) Comply with the standards prescribed in chapter 446 of NAC. (b) Obtain the necessary permits from the Bureau of Health Protection Services of the Division. This Regulation is not met as evidenced by: Surveyor: 27364 Based on observation on 12/1/09, the facility failed to comply with the standards prescribed in chapter 446 of NAC. The following violations were identified: - A cook was observed drinking from an open beverage container on the cook's line. - A rack of cups was blocking access to the hand sink the dishroom. - Three containers of ice cream were observed uncovered in the walk-in freezer. - Wet wiping cloths were left out on the preparation table on the cooks line. - Cleaned kitchenware was observed stacked on a rack while it was still wet. - Dumpsters were overfilled, and the lids were not closed. - Clean clothing for cooks was stored in the restroom. - A wet mop was left in the mop bucket. Severity: 2 Scope: 3	Y 255		

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Y 320 SS=F	449.220(1) Bedroom Doors - Locks NAC 449.220 1. A bedroom door in a residential facility which is equipped with a lock must open with a single motion from the inside unless the lock provides security for the facility and can be operated without a key or any special knowledge. This Regulation is not met as evidenced by: Surveyor: 27364 Based on observation on 12/1/09, the facility failed to ensure all bedrooms were equipped with a single motion lock. Eighty-seven 1 bedroom apartments had 1 bedroom door with a dual motion lock. Twenty-two 2 bedroom apartments had 2 bedroom doors with a dual motion lock. Severity: 2 Scope: 3	Y 320		
Y 356 SS=F	449.222(6) Bathrooms and Toilet Facilities NAC 449.222 6. Bathroom doors that are equipped with locks must open with a single motion from the inside without the use of a key. If a key is required to open a lock from outside the bathroom, the key must be readily available at all times. This Regulation is not met as evidenced by: Surveyor: 27364 Based on observation on 12/1/09, the facility failed to ensure all bathrooms were equipped with a single motion lock. Eighty-seven 1 bedroom apartments had 1 bathroom door with a dual motion lock. Twenty-two 2 bedroom apartments had 3 bathroom doors with a dual motion locks.	Y 356		

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Y 356	Continued From page 4 Twenty-two junior suites had 1 bathroom door with a dual motion lock. Severity: 2 Scope: 3	Y 356		
Y 693 SS=D	449.2712(2) Oxygen-Caregiver monitor resident ability NAC 449.2712 2. The caregivers employed by a residential facility with a resident who requires the use of oxygen shall: (a) Monitor the ability of the resident to operate the equipment in accordance with the orders of a physician. (b) Ensure That: (1) The resident's physician evaluates periodically the condition of the resident which necessitates his use of oxygen; (2) Signs which prohibit smoking and notify persons that oxygen is in use are posted in areas of the facility in which oxygen is in use or is being stored; (3) Persons do not smoke in those areas where smoking is prohibited; (4) All electrical equipment is inspected for defects which may cause sparks. (5) All oxygen tanks kept in the facility are secured in a stand or to a wall; (6) The equipment used to administer oxygen is in good working condition; (7) A portable unit for the administration of oxygen in the event of a power outage is present in the facility at all times when a resident who requires oxygen is present in the facility; and (8) The equipment used to administer oxygen is removed from the facility when it is no longer needed by the resident.	Y 693		

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Y 693	Continued From page 5 This Regulation is not met as evidenced by: Surveyor: 27364 Based on observation on 12/1/09, the facility failed to secure oxygen tanks in a rack or to the wall in 3 of 8 resident rooms that utilized oxygen (bedroom #124, #132 and # 152). Based on observation on 12/1/09, 2 of 8 resident rooms that utilized oxygen failed to post oxygen in use signs (bedroom # 131, and #225) Severity: 2 Scope: 1	Y 693		
Y 878 SS=D	449.2742(6)(a)(1) Medication / Change order NAC 449.2742 6. Except as otherwise provided in this subsection, a medication prescribed by a physician must be administered as prescribed by the physician. If a physician orders a change in the amount or times medication is to be administered to a resident: (a) The caregiver responsible for assisting in the administration of the medication shall: (1) Comply with the order. This Regulation is not met as evidenced by:	Y 878		

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Y 878	Continued From page 6 Surveyor: 27364 Based on record review and interview on 12/1/09, the facility failed to ensure 1 of 15 residents received medications as prescribed (Resident #2). Findings include: Resident #2 was prescribed Alpraxolam (Xanax) .25 milligrams (mg) one tablet three times a day at 8:00 AM, 12:00 PM, and 4:00 PM. The resident missed one 12:00 PM dose of the medication on 12/1/09. The medication technician documented the medication was unavailable in the facility. Employee #7 stated the medication was ordered and should arrive in the facility tomorrow. Severity: 2 Scope: 1	Y 878		